

Vital Health Pharmacy
1825 Fort Street, Victoria, BC V8R 1J6
Fax: 778-433-7071
Phone: 778-433-6060

IV INFUSION OR INJECTION REFERRAL FORM

Today's date _____/_____/_____

Patient Name: _____ PHN#: _____

Patient Phone #: _____ Alternate Phone #: _____

Patient status (if relevant):

Instructions prior to treatment (if any) :

Prescription:

Repeats X _____ Frequency _____

Route of Administration : IV ___ IM ___ SC ___

For Osteoporosis Patients: Enroll in Bone Builder Program
___ (Yes) ___ (No) . This is a 2 hour osteoporosis-specific diet,
exercise, medication review and in-home fall risk assessment.

MD Signature

License # (print clearly)

MD Name (Please print)

MD Fax #

MD Phone #

For Injection at :

Vital Health Pharmacy 1825 Fort Street (across from RJH at Fort and Bank Street, 778-433-6060)

Target date for first Injection / Infusion: _____

Other Instructions / notes:

SEND BY FAX TO VITAL HEALTH PHARMACY AT 778-433-7071
THE RECEIVED COPY WILL BE THE ORIGINAL PRESCRIPTION